STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011970	A. BUILDING: _____ B. WING _____	R-C 03/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILLION PLACE	**449 MAIN ST ANDERSON, IN 46016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint #IN00190704. Complaint #IN00190704 - corrected. Survey Dates: March 7, 2016 Facility Number: 011970 Provider Number: 011970 AIM number: N/A Census Bed Type: Residential: 36 Total: 36 Census Payor Type: Medicaid: 23 Other: 13 Total: 36 Sample: 3 Vermillion Place was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00190704. QR completed by 11474 on March 7, 2016.	{R 000}		